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*Please refer to our [referral email policy](#)

ALL THE FOLLOWING FIELDS ARE REQUIRED INFORMATION

Today's Date: _____

Is this an urgent concern? Y N

Patient Name: _____

Date of Birth: _____ Sex: _____ Preferred Pronoun (if known) _____

Parent/Guardian Name: _____

Contact Phone Number(s): _____

Patient Address: _____

City _____ Zip Code _____

Is an Interpreter Needed? Y N Language: _____

REASON FOR REFERRAL/RECOMMENDATIONS:

Are there any behavioral concerns? Y N If Yes, explain below:

Is the Patient Considered Medically Complex? Y N If Yes, explain below:

Last recall date? _____

Does the patient have X-Rays? Y N If yes, what type and date taken? _____

X-Rays sent by (check one): Email (cpdreferral@uw.edu) Given to parents

Referring Provider, Clinic Name, Address and Phone Number:
